

		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0004077</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Ambassador Nursing Ctr</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>4900 N. Bernard</u> <u>Chicago</u> <u>60625</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
Telephone Number: <u>(773) 583-7130</u> Fax # <u>(773) 583-3929</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Marvin Fox, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	
IDPA ID Number: <u>362900425001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>05/15/77</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236 - 1111</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Ctr# 0004077 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>190</u>	Skilled (SNF)	<u>190</u>	<u>69,350</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>190</u>	TOTALS	<u>190</u>	<u>69,350</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>19,906</u>	<u>2,024</u>	<u>3,248</u>	<u>25,178</u>	8
9	SNF/PED					9
10	ICF	<u>23,648</u>	<u>1,085</u>	<u>687</u>	<u>25,420</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>43,554</u>	<u>3,109</u>	<u>3,935</u>	<u>50,598</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 72.96%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 5/15/77

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 190 and days of care provided 3,248Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Ambassador Nursing Ctr

0004077

Report Period Beginning: 01/01/03

Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	380,943	22,128	11,533	414,604		414,604		414,604		1
2	Food Purchase		193,477		193,477	(24,528)	168,949	(119)	168,830		2
3	Housekeeping	148,643	36,152		184,795		184,795		184,795		3
4	Laundry	53,408	15,095		68,503		68,503		68,503		4
5	Heat and Other Utilities			144,591	144,591		144,591		144,591		5
6	Maintenance	55,877		108,495	164,372		164,372	(17,752)	146,620		6
7	Other (specify):*										7
8	TOTAL General Services	638,871	266,852	264,619	1,170,342	(24,528)	1,145,814	(17,871)	1,127,943		8
	B. Health Care and Programs										
9	Medical Director			15,000	15,000		15,000		15,000		9
10	Nursing and Medical Records	1,777,330	85,423	89,899	1,952,652		1,952,652		1,952,652		10
10a	Therapy	68,765		13,654	82,419		82,419		82,419		10a
11	Activities	68,568	13,021	4,264	85,853		85,853		85,853		11
12	Social Services	87,075		3,146	90,221		90,221		90,221		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,001,738	98,444	125,963	2,226,145		2,226,145		2,226,145		16
	C. General Administration										
17	Administrative	212,794		319,000	531,794		531,794		531,794		17
18	Directors Fees										18
19	Professional Services			64,300	64,300		64,300	(6,162)	58,138		19
20	Dues, Fees, Subscriptions & Promotions			62,527	62,527		62,527	(39,804)	22,723		20
21	Clerical & General Office Expenses	85,112	36,925	107,879	229,916		229,916	(60,221)	169,695		21
22	Employee Benefits & Payroll Taxes			586,885	586,885	24,528	611,413		611,413		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,754	4,754		4,754	(818)	3,936		24
25	Other Admin. Staff Transportation			5,519	5,519		5,519	(2,237)	3,282		25
26	Insurance-Prop.Liab.Malpractice			219,201	219,201		219,201		219,201		26
27	Other (specify):*										27
28	TOTAL General Administration	297,906	36,925	1,370,065	1,704,896	24,528	1,729,424	(109,242)	1,620,182		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,938,515	402,221	1,760,647	5,101,383		5,101,383	(127,113)	4,974,270		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Ambassador Nursing Ctr

#0004077

Report Period Beginning:

01/01/03

Ending:

12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			59,616	59,616		59,616	89,031	148,647			30
31	Amortization of Pre-Op. & Org.			6,995	6,995		6,995	2,685	9,680			31
32	Interest			85,701	85,701		85,701	107,996	193,697			32
33	Real Estate Taxes			219,889	219,889		219,889		219,889			33
34	Rent-Facility & Grounds			148,689	148,689		148,689	(148,689)				34
35	Rent-Equipment & Vehicles			19,223	19,223		19,223		19,223			35
36	Other (specify):*											36
37	TOTAL Ownership			540,113	540,113		540,113	51,023	591,136			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		163,098	366,886	529,984		529,984		529,984			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			104,025	104,025		104,025		104,025			42
43	Other (specify):*	25,331			25,331		25,331	(25,331)				43
44	TOTAL Special Cost Centers	25,331	163,098	470,911	659,340		659,340	(25,331)	634,009			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,963,846	565,319	2,771,671	6,300,836		6,300,836	(101,422)	6,199,414			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Ctr

0004077

Report Period Beginning: 01/01/03

Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	31,883	30		9
10	Interest and Other Investment Income	(11)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(119)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,351)	21		18
19	Entertainment	(1,631)	21		19
20	Contributions	(625)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(40,117)	21		24
25	Fund Raising, Advertising and Promotional	(38,628)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,980)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(177)	20		28
29	Other-Attach Schedule	(191,631)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (249,388)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	147,966		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 147,966		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (101,422)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Ambassador Nursing Ctr

0004077

Report Period Beginning: 01/01/03

Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES			Amount	Reference
1	Misc Income	\$	(961)	21 1
2	Marketing Salaries		(25,334)	43 2
3	Bank Charges		(6,993)	23 3
4	Use Tax		(2,580)	21 4
5	Adjust Legal Account to Actual		(2,119)	19 5
6	Prior Year Legal Fees		(370)	19 6
7	Capitalized R&M		(17,752)	06 7
8	Professional Fees - PY Account		(2,000)	19 8
9	Out of State Travel / Marketing Travel		(2,237)	25 9
10	R.C.T.C. - COPE		(374)	30 10
11	Marketing Services		(1,250)	19 11
12	Building Co - Loan Fees Write Off		(64,244)	23 12
13	Building Co - Bank Charges		(3,631)	23 13
14	Building Co - License Fees		(10)	20 14
15	Building Co - Professional Fees		(925)	19 15
16	Building Co - Management Fees		(60,800)	19 16
17	Non-allowable Seminar		(810)	24 17
18	Non-allowable Legal		(432)	19 18
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97				97
98				98
99				99
100				100
101	Total		(191,631)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Ambassador Nursing Ctr

0004077

Report Period Beginning:

01/01/03

Ending:

12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(119)											(119)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(17,752)											(17,752)	6
7	Other (specify):*													7
8	TOTAL General Services	(17,871)											(17,871)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(67,087)	60,925										(6,162)	19
20	Fees, Subscriptions & Promotions	(39,819)	15										(39,804)	20
21	Clerical & General Office Expenses	(128,096)	67,875										(60,221)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(818)											(818)	24
25	Other Admin. Staff Transportation	(2,237)											(2,237)	25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	TOTAL General Administration	(238,057)	128,815										(109,242)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(255,928)	128,815										(127,113)	29

Summary B

12/31/03

[illegible]

Facility Name & ID Number Ambassador Nursing Ctr# 0004077

Report Period Beginning:

01/01/03

Ending:

12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Ambassador Building Partnership		Building Partnership

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 148,689	Ambassador Building Partnership		\$	(148,689)	1
2	V	32 Mortgage Interest				108,007	108,007	2
3	V	21 Loan Fees Write Off				64,244	64,244	3
4	V	31 Amortization Expense				2,685	2,685	4
5	V	30 Depreciation Expense				57,148	57,148	5
6	V	21 Bank Charges				3,631	3,631	6
7	V	20 License Fees				15	15	7
8	V	19 Professional Fees				925	925	8
9	V	19 Management Fees				60,000	60,000	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 148,689			\$ 296,655	\$ * 147,966	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Ctr# 0004077Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Ctr# 0004077Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Ctr# 0004077Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Ctr# 0004077Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Ctr# 0004077Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Ctr# 0004077Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Ctr# 0004077Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Ctr# 0004077Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Ctr# 0004077Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Ctr # 0004077 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Meisels	Executive Admin.	Administrative	Relative	See Attached	8.00	20.00%	See Attached	\$ 152,533	17-1,17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 152,533		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Ctr # 0004077 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Ctr# 0004077

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Ctr# 0004077

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Ctr# 0004077

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Ctr # 0004077 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

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Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Ctr# 0004077

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Ctr# 0004077

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Ctr# 0004077

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Ctr# 0004077

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Ctr# 0004077

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related Long-Term													
1	Continental Care	X		Mortgage			\$	515,302			\$	32,205	1	
2	Bank Financial		X	Mortgage				2,009,887				108,007	2	
3													3	
4													4	
5	See Supplemental Schedule												5	
	Working Capital													
6	Bank Financial		X	Line of Credit				1,226,983				53,295	6	
7	Universal		X	Insurance								201	7	
8	See Supplemental Schedule												8	
9	TOTAL Facility Related						\$	3,752,172				\$	193,708	9
	B. Non-Facility Related*													
10													10	
11	Interest Income											(11)	11	
12													12	
13	See Supplemental Schedule												13	
14	TOTAL Non-Facility Related						\$					\$	(11)	14
15	TOTALS (line 9+line14)						\$	3,752,172				\$	193,697	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8							\$	\$			\$	8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital											14	
	B. Non-Facility Related*												
15							\$	\$			\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

- * Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT
- ** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Ambassador Nursing Ctr**# **0004077** Report Period Beginning: **01/01/03** Ending: **12/31/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2002 report.		\$ 251,200	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 233,489	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (17,711)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 237,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 219,889	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1998 209,453	8	
	1999 208,047	9	
	2000 225,047	10	
	2001 230,900	11	
	2002 233,489	12	
2003 Accrual = 2002 Tax \$233,489 x 1.018 = \$237,600 (rounded)			
		13	FROM R. E. TAX STATEMENT FOR 2002 \$ 13
		14	PLUS APPEAL COST FROM LINE 5 \$ 14
		15	LESS REFUND FROM LINE 6 \$ 15
		16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Ambassador Nursing Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0004077

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>13-11-418-021-0000</u>	<u>Long Term Care Property</u>	\$ <u>20,603.08</u>	\$ <u>20,603.08</u>
2. <u>13-11-418-022-0000</u>	<u>Long Term Care Property</u>	\$ <u>75,723.88</u>	\$ <u>75,723.88</u>
3. <u>13-11-418-028-0000</u>	<u>Long Term Care Property</u>	\$ <u>37,188.24</u>	\$ <u>37,188.24</u>
4. <u>13-11-418-026-0000</u>	<u>Long Term Care Property</u>	\$ <u>96,270.71</u>	\$ <u>96,270.71</u>
5. <u>13-11-416-033-0000</u>	<u>Long Term Care Property</u>	\$ <u>3,702.68</u>	\$ <u>3,702.68</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>233,488.59</u></u>	\$ <u><u>233,488.59</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Ambassador Nursing Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0004077

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 40,497

B. General Construction Type:
 Exterior
 Brick
 Frame
 Number of Stories
 3

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☒ YES
 ☐ NO

If so, please complete the following:

1. Total Amount Incurred:
 70,136

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 9,680

4. Dates Incurred:

Nature of Costs:
 Loan Fees

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1977	\$ 127,394	1
2					2
3	TOTALS			\$ 127,394	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Ctr

0004077

Report Period Beginning:

01/01/03

Ending:

12/31/03

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1983		820		20	-		820	9
10	Various		1984		11,000		20	-		11,000	10
11	Various		1986		44,252		20	2,329	2,329	39,926	11
12	Various		1987		5,800		20	290	(290)	4,785	12
13	Various		1988		1,825		20	58	58	889	13
14	Various		1990		48,352		20	1,708	1,708	22,659	14
15	Various		1991		1,571		20	79	79	967	15
16	Various		1992		8,653		20	432	432	4,932	16
17	Various		1993		55,217		20	2,531	2,531	35,725	17
18	Various		1994		8,007		20	401	401	3,531	18
19	Various		1995		35,063		20	1,753	1,753	14,633	19
20	Various		1996		120,434		20	6,022	6,022	45,642	20
21	Various		1997		37,040		20	1,853	1,853	11,874	21
22	Various		1998		127,674		20	6,195	6,195	32,737	22
23	Various		1999		139,435		20	6,972	6,972	30,141	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		1,714,426	57,148		57,148		1,514,415	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)			22,217			(22,217)		68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		\$ 2,359,569	\$ 79,365		\$ 87,771	\$ 7,826	\$ 1,774,676	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

****Improvement type must be detailed in order for the cost report to be considered complete.**

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,437,457	\$ 79,365		\$ 90,438	\$ 11,073	\$ 1,784,143	1
2	Tower Fan	2000	1,016		20	51	51	153	2
3	Plumbing	2000	503		20	25	25	75	3
4	Doors	2000	670		20	34	34	101	4
5	Walk-In Freezer	2000	521		20	26	26	78	5
6	Fireproof Walls	2000	550		20	28	28	83	6
7	Fan Motor	2000	1,276		20	64	64	192	7
8	Toilet	2000	698		20	35	35	105	8
9	Fire Alarm	2000	528		20	26	26	79	9
10	Fire System Horn	2000	700		20	35	35	105	10
11	Smoke Detectors	2000	1,224		20	61	61	183	11
12	Fire Stoppers	2001	3,639		20	93	93	276	12
13	Install Firestopping	2001	16,950		20	435	435	1,213	13
14	Install Speakers	2001	850		20	22	22	61	14
15	Install Firestopping	2001	21,850		20	560	560	1,564	15
16	Slot Signs	2001	1,968		20	50	50	136	16
17	Furnish & Install Lt	2001	775		20	20	20	54	17
18	Fire Stoppers	2001	1,819		20	47	47	122	18
19	Building Firewall	2001	1,525		20	39	39	109	19
20	Replace Cooling Towe	2001	15,650		20	401	401	1,054	20
21	Concrete Front Entnc	2001	6,500		20	167	167	368	21
22	Install Ext Exit Sgn	2001	2,019		20	52	52	115	22
23	Antenna W/Signalling	2001	2,141		20	55	55	121	23
24	Install Motor Pump	2001	1,100		20	28	28	60	24
25	Security & Alrm Syst	2001	1,011		20	26	26	55	25
26	Repair Fire Alarm	2001	1,469		20	38	38	77	26
27	Boiler Repair	2001	1,853		20	48	48	137	27
28	Install Motor Pump	2001	1,324		20	34	34	69	28
29	Furnish & Install Bl	2001	620		20	31	31	83	29
30	Cubicle Curtain	2001	2,296		20	115	115	278	30
31	Firestopper	2001	565		20	28	28	83	31
32	Motor Work	2001	824		20	41	41	116	32
33	Fire Pump	2001	664		20	33	33	94	33
34	TOTAL (lines 1 thru 33)		\$ 2,532,555	\$ 79,365		\$ 93,186	\$ 13,821	\$ 1,791,542	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,532,555	\$ 79,365		\$ 93,186	\$ 13,821	\$ 1,791,542	1
2	Cubicle Curtain	2001	721		20	36	36	102	2
3	Condensor Chiller	2001	1,011		20	51	51	139	3
4	Lamps	2001	654		20	33	33	82	4
5	Carpet Seam Work	2001	525		20	26	26	66	5
6	Hot Water Valve Seal	2001	517		20	26	26	63	6
7	Install Faucets	2002	648		20	65	65	119	7
8	Install Faucets	2002	1,780		20	178	178	326	8
9	Install Smoke/Fire Damper	2002	1,170		20	117	117	205	9
10	Concrete Restoration	2002	4,575		20	458	458	763	10
11	Walk In Freezer	2002	2,420		20	242	242	383	11
12	Leasehold Improvements	2002	2,750		20	275	275	413	12
13	Post Terminal/Battery Cable Generator	2002	850		20	43	43	50	13
14	Water Pump - Generator	2002	1,216		20	61	61	66	14
15	Fire Alarm	2002	592		20	85	85	169	15
16	Tiles	2002	1,053		20	105	105	211	16
17	Cooling System	2002	4,287		20	429	429	750	17
18	Painting	2002	2,725		20	1,363	1,363	2,725	18
19	Call System	2002	516		20	34	34	43	19
20	Receptacles	2002	600		20	60	60	70	20
21	Window Shades Wound Care	2003	1,281		20	21	21	21	21
22	Wall Covering	2003	16,578		20	69	69	69	22
23	Jetvac Floor Drains	2003	2,451		20	143	143	143	23
24	Sump Pump	2003	1,761		20	73	73	73	24
25	10 Push Button Locks	2003	1,377		20	57	57	57	25
26	Mixing Valve High Temp	2003	3,171		20	106	106	106	26
27	Wound Care Unit Decorat	2003	2,564		20	85	85	85	27
28	Damper Test List Zones	2003	1,800		20	19	19	19	28
29	Hot Water Pump Repair	2003	1,323		20	50	50	50	29
30	Fire Door	2003	710		20	15	15	15	30
31	Plumbing Supplies	2003	593		20	10	10	10	31
32	Hot Water - Plumbing	2003	548		20	9	9	9	32
33	Electrical Receptacles	2003	2,160		20	27	27	27	33
34	TOTAL (lines 1 thru 33)		\$ 2,597,482	\$ 79,365		\$ 97,557	\$ 18,192	\$ 1,798,971	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,597,482	\$ 79,365		\$ 97,557	\$ 18,192	\$ 1,798,971	1
2	Boiler Repair	2003	5,395		20	22	22	22	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,602,877	\$ 79,365		\$ 97,579	\$ 18,214	\$ 1,798,993	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 2,602,877	\$ 79,365		\$ 97,579	\$ 18,214	\$ 1,798,993	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,602,877	\$ 79,365		\$ 97,579	\$ 18,214	\$ 1,798,993	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 2,602,877	\$ 79,365		\$ 97,579	\$ 18,214	\$ 1,798,993	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,602,877	\$ 79,365		\$ 97,579	\$ 18,214	\$ 1,798,993	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 2,602,877	\$ 79,365		\$ 97,579	\$ 18,214	\$ 1,798,993	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,602,877	\$ 79,365		\$ 97,579	\$ 18,214	\$ 1,798,993	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 2,602,877	\$ 79,365		\$ 97,579	\$ 18,214	\$ 1,798,993	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,602,877	\$ 79,365		\$ 97,579	\$ 18,214	\$ 1,798,993	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 2,602,877	\$ 79,365		\$ 97,579	\$ 18,214	\$ 1,798,993	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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19									19
20									20
21									21
22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,602,877	\$ 79,365		\$ 97,579	\$ 18,214	\$ 1,798,993	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 2,602,877	\$ 79,365		\$ 97,579	\$ 18,214	\$ 1,798,993	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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19									19
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,602,877	\$ 79,365		\$ 97,579	\$ 18,214	\$ 1,798,993	34

**Improvement type must be detailed in order for the cost report to be considered complete.
 SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued) B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	190		1977	1977	\$ 1,714,426	\$ 57,148		\$ 57,148	\$	\$ 1,514,415	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.
 **Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total
 SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,714,426	\$ 57,148		\$ 57,148	\$	\$ 1,514,415	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)												
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.												
	1		2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9											9	
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36											36	

*Total beds on this schedule must agree with page 2.
 **Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total
 SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 536,355	\$ 36,118	\$ 50,643	\$ 14,525	10	\$ 350,328	71
72	Current Year Purchases	8,511	1,281	425	(856)	10	425	72
73	Fully Depreciated Assets	416,235				10	416,235	73
74								74
75	TOTALS	\$ 961,101	\$ 37,399	\$ 51,068	\$ 13,669		\$ 766,988	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$			\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$			\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,691,372	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 116,764	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 148,647	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 31,883	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,565,981	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	\$ 108,258	92
93			93
94			94
95		\$ 108,258	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 19,223

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$

13. /2005 \$

14. /2006 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 154,697
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				74,021			74,021	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 03	hrs				138,168			138,168	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39 - 02	# of prescrpts					118,690		118,690	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)										
10			hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): See Supplemental						44,408			44,408	13
14	TOTAL			\$		\$ 366,886	\$ 163,098		\$	529,984	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,436	\$ 36,124	1
2	Cash-Patient Deposits	65,823	65,823	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,585,977	1,701,427	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	98,123	98,123	6
7	Other Prepaid Expenses	151	151	7
8	Accounts Receivable (owners or related parties)	871,376	1,236,677	8
9	Other(specify): See Attached Schedule	185,016	301,760	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,808,902	\$ 3,440,085	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		127,394	13
14	Buildings, at Historical Cost		1,714,426	14
15	Leasehold Improvements, at Historical Cost	699,762	710,855	15
16	Equipment, at Historical Cost	807,169	1,034,751	16
17	Accumulated Depreciation (book methods)	(896,025)	(2,649,041)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		70,136	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(1,950)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	108,258	108,258	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 719,164	\$ 1,114,829	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,528,066	\$ 4,554,914	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,015,566	\$ 1,015,567	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	65,119	65,119	28
29	Short-Term Notes Payable	515,302	515,302	29
30	Accrued Salaries Payable	94,347	94,347	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,767	1,767	31
32	Accrued Real Estate Taxes(Sch.IX-B)	237,600	237,600	32
33	Accrued Interest Payable	10,467	17,825	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	91,000	91,000	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,031,168	\$ 2,038,527	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,226,983	1,226,983	39
40	Mortgage Payable		2,009,887	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,226,983	\$ 3,236,870	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,258,151	\$ 5,275,397	46
47	TOTAL EQUITY (page 18, line 24)	\$ 269,915	\$ (720,483)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,528,066	\$ 4,554,914	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (177,858)	1
2	Restatements (describe):		2
3	See Attached	264,023	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 86,165	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	233,750	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(50,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 183,750	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 269,915	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Ambassador Nursing Ctr

0004077

Report Period Beginning: 01/01/03

Ending:

12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,457,897	1
2	Discounts and Allowances for all Levels	(1,253,208)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,204,689	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,163,341	6
7	Oxygen	8,135	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,171,476	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	101,889	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,686	19
20	Radiology and X-Ray	6,335	20
21	Other Medical Services	35,039	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 156,949	23
	D. Non-Operating Revenue		
24	Contributions	900	24
25	Interest and Other Investment Income***	11	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 911	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	561	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 561	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,534,586	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,170,342	31
32	Health Care	2,226,145	32
33	General Administration	1,704,896	33
	B. Capital Expense		
34	Ownership	540,113	34
	C. Ancillary Expense		
35	Special Cost Centers	555,315	35
36	Provider Participation Fee	104,025	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,300,836	40
41	Income before Income Taxes (line 30 minus line 40)**	233,750	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 233,750	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Ambassador Nursing Ctr# 0004077Report Period Beginning: 01/01/03Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,557	1,785	\$ 56,632	\$ 31.73	1
2	Assistant Director of Nursing	2,200	2,317	60,392	26.06	2
3	Registered Nurses	24,201	26,789	587,164	21.92	3
4	Licensed Practical Nurses	13,818	14,305	321,092	22.45	4
5	Nurse Aides & Orderlies	70,825	76,484	740,241	9.68	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,308	5,629	68,765	12.22	8
9	Activity Director	2,033	2,091	25,097	12.00	9
10	Activity Assistants	5,390	5,932	43,471	7.33	10
11	Social Service Workers	4,937	5,499	87,075	15.83	11
12	Dietician					12
13	Food Service Supervisor	1,855	2,139	38,563	18.03	13
14	Head Cook					14
15	Cook Helpers/Assistants	37,722	40,860	342,380	8.38	15
16	Dishwashers					16
17	Maintenance Workers	3,492	3,682	55,877	15.18	17
18	Housekeepers	16,695	17,965	148,643	8.27	18
19	Laundry	7,417	7,790	53,408	6.86	19
20	Administrator	1,889	2,033	71,341	35.09	20
21	Assistant Administrator	1,841	2,091	43,920	21.00	21
22	Other Administrative	2,086	2,091	97,533	46.64	22
23	Office Manager					23
24	Clerical	6,112	6,544	85,112	13.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	856	924	11,809	12.78	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	981	1,046	25,331	24.22	33
34	TOTAL (lines 1 - 33)	211,215	227,996	\$ 2,963,846 *	\$ 13.00	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	222	\$ 11,533	01-03	35
36	Medical Director	monthly	15,000	09-03	36
37	Medical Records Consultant	monthly	1,696	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	301	13,654	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	95	4,264	11-03	44
45	Social Service Consultant	61	3,146	12-03	45
46	Other(specify)				46
47	<u>Wound Care Consultant</u>	272	27,200	10-03	47
48					48
49	TOTAL (lines 35 - 48)	951	\$ 76,493		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	121	\$ 5,912	10-03	50
51	Licensed Practical Nurses	1,286	54,791	10-03	51
52	Nurse Aides	16	300	10-03	52
53	TOTAL (lines 50 - 52)	1,423	\$ 61,003		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ambassador Nursing Ctr# 0004077Report Period Beginning: 01/01/03Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Aaron Butcher (1/1-3/2/03)	Administrator	0	\$ 14,432	Workers' Compensation Insurance	\$ 54,470	IDPH License Fee	\$ 400	
William McNiff (3/24-12/31/03)	Administrator	0	56,909	Unemployment Compensation Insurance	37,839	Advertising: Employee Recruitment	10,035	
Patricia Correa	Asst. Admin.	0	43,920	FICA Taxes	221,408	Health Care Worker Background Check	348	
David Meisels	Executive Admin.	Relative	97,533	Employee Health Insurance	208,993	(Indicate # of checks performed <u>29</u>)		
				Employee Meals	24,528	Advertising / Yellow Pages	38,805	
				Illinois Municipal Retirement Fund (IMRF)*		ICLTC Dues	3,311	
				Chicago Head Tax	5,118	Dues & Subscriptions	284	
				401K Expense	2,222	Licenses / Permits / Fees	8,345	
				Other Employee Benefits	16,063			
				Union Pension	18,340			
				Life Insurance	8,688	Less: Public Relations Expense (
				Holiday Expense	13,744	Non-allowable advertising	(38,628)	
						Yellow page advertising	(177)	
TOTAL (agree to Schedule V, line 17, col. 1)						TOTAL (agree to Sch. V,	\$ 22,723	
(List each licensed administrator separately.)			\$ 212,794			line 20, col. 8)		
B. Administrative - Other				TOTAL (agree to Schedule V,				\$ 611,413
				line 22, col.8)				
Description			Amount	E. Schedule of Non-Cash Compensation Paid				
Olympia Group, LLC (the owners of Olympia Group are			\$ 264,000	to Owners or Employees				
not related to the owners of this facility)				Description	Line #	Amount		
David Meisels			55,000					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 319,000					
(Attach a copy of any management service agreement)								
C. Professional Services				G. Schedule of Travel and Seminar**				
Vendor/Payee	Type		Amount	Description				
Sachnoff & Weaver	Legal		\$ 6,183	Out-of-State Travel				
Levenfeld & Thorpe	Legal		1,675					
Winston & Strawn	Legal		5,312					
Accrual - Adjusted Page 5	Legal		2,110	In-State Travel				
	Legal		(2,886)					
Frost, Ruttenberg & Rothblatt	Accounting		26,771					
Econocare	Purchasing Consultant		250					
HDSI	Computer Services		8,296	Seminar Expense				
Accu-Med Services	Computer Services		2,216					
Parallax Tech. Services	Computer Services		2,690					
Quality Care (PY adj page 5)	Computer Services		2,000					
See Supplemental Schedule			9,683	Entertainment Expense (
TOTAL (agree to Schedule V, line 19, column 3)				(agree to Sch. V,				
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 64,300	line 24, col. 8)				
				TOTAL				
				\$ 3,936				

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

<p>Facility Name & ID Number Ambassador Nursing Ctr</p> <p>XX. GENERAL INFORMATION:</p> <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>Yes</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>Yes</u> If YES, give association name and amount. <u>Illinois Council on Long Term Care \$3685</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>Yes</u> If YES, have these costs been properly adjusted out of the cost report? <u>Yes</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? _____</p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u> What was the average life used for new equipment added during this period? <u>10 yrs</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>1,827</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation. _____</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u> If YES, give effective date of lease. _____</p> <p>(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____</p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ <u>104,025</u> This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation. _____</p>	<p style="text-align: center;">STATE OF ILLINOIS</p> <p># 0004077 Report Period Beginning: 01/01/03 Ending: 12/31/03</p> <p>(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? <u>Yes</u></p> <p>(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? <u>No</u> For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>24,528</u> Has any meal income been offset against related costs? <u>No</u> Indicate the amount. \$ _____</p> <p>(16) Travel and Transportation a. Are there costs included for out-of-state travel? <u>No</u> If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____ c. What percent of all travel expense relates to transportation of nurses and patients? <u>None</u> d. Have vehicle usage logs been maintained? <u>N/A</u> e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>N/A</u> f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>Yes</u> g. Does the facility transport residents to and from day training? <u>No</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____</p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>No</u> Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____</p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? <u>Yes</u> Attach invoices and a summary of services for all architect and appraisal fees.</p>
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